Medi Assist

E-card Claims Plan hospitalization Hospitals

XAP33085707

Date :06 Jun 2023

To,

The Administrator / Medical Superintendent,
I Clinix Advanced Eye Care,
27/171 Vikram Vihar ,Lajpat nagar -4 , Near Moolchand Metro Station, New Delhi, NEW DELHI
Hospital ID: (208776)
Rohini Id: 8900080386488

Dear Partner,

With reference to your request (33085707) for final cashless pre-authorization, we here by authorize INR **24000** against your final bill amount INR **34000**. The details of the pre-authorization are as follows:

Patient Details

Patient Name	Vijay Saraf
Relation to Primary Beneficiary	Father
Age	64
Gender	M
Insurance Company	The New India Assurance Co. Ltd
Medi Assist ID	5109938202
Policy Holder	KPMG Global Delivery Center Private Limted
IP No.	00
Policy No.	12100034230400000006_Delivery
Policy Period	01 Apr 2023 to 31 Mar 2024
Primary Beneficiary	Asttha Surana
Primary Beneficiary Employee ID	122999
Insurer Claim No	TP00312100023900023102
Insurer Member ID	

Treatment Details

Provisional Diagnosis	Cortical age-related cataract, left eye
Expected Date Of Admission	06 Jun 2023
Treating Doctor	
Procedure / Treatment Planned	Phaco with IOL-Extracapsular crystalline lens extraction by phacoemulsification with IOL (Removal of cataract-phaco with IOL)
Estimated Date of Discharge	06 Jun 2023
Room Category Occupied	Day care
Length Of Stay	0
Eligible Room Category	

Authorization Details

#	Status	Received Date	Cumulative Amount	Cumulative Authorized
1	Pre-Auth Processed	05 Jun 2023 15:06	34000	24000
2	Pre-Auth Processed	06 Jun 2023 14:06	34000	24000

Total Authorized amount Rs 24000 (Twenty Four Thousand).

Authorization Remarks :

approved

Note: If Top Up is available and applicable, as per policy conditions, Top Up claims will be processed and additional amounts will be approved along with base amount as per your benefit.

Hospital Agreed Tariff :

I. Package Case	
Agreed Package Rate	34000 (1 Package(s) Applied)
Package charges exclude cost towards implants/co-morbidity/extended stay	

II. Non Package Case		
Room Type	**Room Rent**	**Nursing**
NA	NA	NA

Consultation Visit Charges/ Surgeon's fee/ OT/ Anaesthetist : As per customary and reasonable charges

Authorization Summary

Total bill amount (INR)	34000
Other Deductions(INR)*	0
Excess of Defined / Ailment Limit (INR)	1500
Copay (INR)	8500
Deductibles (INR)	0
Total Authorized Amount(INR)	24000
Amount to be paid by Insured (INR)	10000

***Deduction Details**

S.no	Description	Bill Amount (INR)	Deducted Amount (INR)	Admissible Amount (INR)	Deduction Reason
No Non-Medical Expences					

Terms and conditions for authorization

1. Cashless authorization letter issued on the basis of information provided in pre authorization form. In case of misrepresentation/concealment of facts, any material difference/deviation/ discrepancy in information is observed in discharge summary / IPD records then cashless authorization stand null & void. At any point of claim processing Insurer or TPA reserves right to raise queries for any other document to ascertain the admissibility of claim.
2. KYC (know your customer) details of proposer/employee/beneficiary are mandatory for claim payout above Rs.1 lakh.
3. Network provider shall not collect any additional amount from the individual in excess of Agreed Package Rates except cost towards non admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in Package)
4. Network provider shall not make any recovery from the deposit amount collected from the insured except for the cost towards non admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in Package)
5. In the event of unauthorized recovery of any additional amount from the insured in excess of Agreed Package Rates, the authorized TPA/Insurance company reserves the right to recover the same or get the same refunded to the policy holder from the network provider and/or take necessary action as provided under the MOU.
6. Where treatment / procedure to be carried out by a Doctor/Surgeon of insured's choice (not empaneled with the Hospital) network provider may give treatment after obtaining specific consent of the policyholder.
7. Differential cost borne by the policyholder may be reimbursed by Insurer subject to terms and conditions of the policy.

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed discharge summary and all bills from the Hospital
2. Cash memos from the Hospitals / Chemists supported by proper prescriptions
3. Diagnostic Test Reports and Receipts supported by note from the attending Medical Practitioner / Surgeon recommending such diagnostic tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon giving patient's condition and advice on discharge
6. Please send cashless documents to address mentioned in last page of letter. (Beneath signature)
7. Final hospital bills should be issued in the name of The New India Assurance Co. Ltd as a payer for payment of cashless claims. This is a mandatory requirement for claim settlement.

Cashless Checklist

1. Photo ID Card
2. Address Proof
3. Discharge Summary (Mandatory)
4. Final Bill (Mandatory)

Also note that

- The following expenses will not be payable:
  - Expenses on investigations / diagnostic tests, etc. which are not related to the condition for which admission is sought
  - Expenses related to medicines/drugs incurred post discharge
  - Expenses not covered / not payable as per health insurance policy terms and conditions
- The following documents must be submitted in full within 7 days from date of discharge to enable settlement of claim:
  - Settlement of claim, failing which Authorization(s) issued for this hospitalization would be treated as void
  - Original cashless claim form in IRDAI format
  - Original bill in IRDAI format, duly signed by the patient / representative
  - Original discharge summary in IRDAI format, duly signed by the patient / representative
  - Break-up of the bill amount being claimed, including pharmacy, investigations, etc.
  - All original investigation reports and X ray films etc
  - Original letter/s of clarification provided during the authorization
  - Original sticker for all the implants & high value consumables
  - Attested copy of the receipt for the amount settled by the patient / representative.
  - Attested copy of the OT notes for surgical cases
  - Self-attested copy of photo id card of the patient is mandatory; any one of these documents will be accepted - (a) Driving Licence (b) PAN Card

(c)Voter ID Card (d) School/College Id card for students (e) Passport (f) ID card issued by present employer

- If the bill amount exceeds INR 1 lakh, it is mandatory to collect the address proof of the Primary Beneficiary; any of these documents will be accepted - (a)Driving Licence (b) Passport (c) Voter ID Card (d) Aadhar Card

Please note that the amount authorised is provisional and is subject to change based on the final bill and discharge summary, and deduction of TDS, as applicable.

Note: As per Modified Guidelines on Standards and Benchmarks for Hospitals in the Provider Network issued by IRDAI vide Circular Ref: IRDA/HLT/REG/GDL/114/07/2018 dated 27th July 2018, your Hospital is mandatorily required to Register with ROHINI and obtain either Pre-entry level Certificate (or higher level of certificate) issued by NABH or State Level Certificate (or higher level of certificate) under NQAS, issued by National Health Systems Resources Centre (NHSRC) on or before July 26, 2019.

QUICK LINKS:

For partner hospital

View this claim on **IHX**. Not on IHX yet? **Sign Up** now.
View important notes related to cashless claims

For member beneficiary

Pre- and post-hospitalization expenses? Raise a reimbursement claim on **MediBuddy**.
Learn more about **common reasons for difference in claimed and approved amounts**
Get the MediBuddy app

Warm Regards,

Medi Assist Insurance TPA Pvt. Ltd
CIN: U85199KA1999PTC025676.
Cashless Processing Centre
#58/1A, Singhasandra.
Hosur Main Road,
Begur Post.
Bangalore. PIN - 560068.
Helpline: **080-22068666**

Disclaimer: *The TPA extends the cashless facility subject to the standard terms & conditions of the policy and the information provided in the cashless request form. We suggest that the patient continues with the treatment as advised by the treating doctor, irrespective of the pre-authorization/cashless facility.*

App Connect

THIS IS A SYSTEM GENERATED CORRESPONDENCE. PLEASE DO NOT REPLY TO THIS EMAIL

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

(To be Filled in block letters)

DETAILS OF HOSPITAL

a) Name of the hospital:

a) Hospital ID:

c) Type of Hospital: Network : ☑ Non Network : ☐ (if non network fill section E)

c) Name of the treating doctor:

e) Qualification: MBBS MD

f) Registration No. with State Code:

g) Phone No.

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:

b) IP Registration Number:

c) Gender: Male ☑ Female ☐

d) Age: Years Months

e) Date of birth:

f) Date of Admission:

g) Time:

h) Date of Discharge:

i) Time:

j) Type of Admission: Emergency ☐ Planned ☑ Day Care ☐ Maternity ☐

k) If Maternity

i) Date of Delivery:

ii) Gravida Status: :

l) Status at time of discharge: Discharge to home ☑ Discharge to another hospital ☐ Deceased ☐

m) Total claimed amount

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)

	ICD 10 Codes	Description
i. Primary Diagnosis		
ii. Additional Diagnosis:		
iii. Co-morbidities:		
iv. Co-morbidities:		

b)

	ICD 10 PCS	Description
i. Procedure 1:		
ii. Procedure 2:		
iii. Procedure 3:		
iv. Details of Procedure:		

c) Pre-authorization obtained: ☑ Yes ☐ No d) Pre-authorization Number:

e) If authorization by network hospital not obtained, give reason:

f) Hospitalization due to injury: ☐ Yes ☑ No i. If Yes, give cause Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐

ii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this: ☐ Yes ☑ No (If Yes, attach reports) iii. If Medico legal: ☐ Yes ☑ No iv. Reported to Police ☐ Yes ☑ No

v. FIR No. vi. If not reported to police give reason:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☑ Claim Form duly signed
- ☑ Original Pre-authorization request
- ☑ Copy of the Pre-authorization approval letter
- ☑ Copy of Photo ID Card of patient Verified by hospital
- ☑ Hospital Discharge summary
- ☑ Operation Theatre Notes
- ☑ Hospital main bill
- ☑ Hospital break-up bill
- ☑ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☑ Doctor's reference slip for investigation
- ☑ ECG
- ☑ Pharmacy bills
- ☑ MLC reports & Police FIR
- ☑ Original death summary from hospital where applicable
- ☑ Any other, please specify

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital

City: State:

Pin Code: b) Phone No. c) Registration No. with State Code:

d) Hospital PAN: e) Number of inpatient beds f) Facilities available in the hospital i. OT ☑ Yes ☐ No ii. ICU ☐ Yes ☑ No

iii. Others:

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date:

Place:

Signature and Seal of the Hospital Authority:

CLINIX Advanced Eye Care Lajpat Nagar-IV N.D.-24

SECTION A | SECTION B | SECTION C | SECTION D | SECTION E | SECTION F

Medi Assist

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY

PART C (Revised)

TO BE FILLED IN BLOCK LETTERS

Name of the hospital: TECHNIK ADVANCED EYE CARE

Hospital location: 27/1-1 VIKRAM VIHAR LAJPAT NAGAR — Hospital ID:

Hospital email ID: — ROHINI ID:

DETAILS OF THIRD PARTY ADMINISTRATOR

a) Name of TPA company: Medi Assist Insurance TPA Pvt Ltd — b) Phone no.: 080 22068666 — c) Toll Free Fax no.: 1800 425 9559

TO BE FILLED BY INSURED/PATIENT

a) Name of the patient: VIJAY SARAF

b) Gender: [✓] Male [ ] Female [ ] Third gender — c) Contact no.: 977356210[illegible] — d) Alternate contact no.:

e) Age: Years 63 Months MM — f) Date of birth: 22/10/1959 — g) Insurer ID card no.: 5109938202

h) Policy number/Name of corporate: KPMG GLOBAL DELIVERY CENTRE PM — i) Employee ID: 122999

j) Currently do you have any other medical claim/health Insurance: [ ] Yes [✓] No — j.1) Insurer name: ASTHA SURANA

j.2) Give details:

k) Do you have a family physician, if yes: Name: — N/A — k.1) Contact no.:

L) Occupation of insured patient:

m) Address of insured patient:

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

a) Name of the treating doctor: DR [illegible] — b) Contact no.: 9911392410

c) Name of Illness/disease with presenting complaints: BOV IN B/E

d) Relevant clinical findings: B/E CATARACT

e) Duration of the present ailment: days — e.1) Date of first consultation: DD MM YYYY

e.2) Past history of present ailment if any:

f) Provisional diagnosis: L/E CATARACT — f.1) ICD 10 code:

g) Proposed line of treatment: [ ] Medical management [✓] Surgical management [ ] Intensive care [ ] Investigation [ ] Non-Allopathic treatment

h) If investigation and/or medical management, provide details: — h.1) Route of drug administration: [ ] IV [ ] Oral [ ] Other — N/A —

i) If Surgical, name of surgery: L/E (MICS) IOL — i.1) ICD 10 PCS code:

j) If other treatments provide details: — N/A —

k) How did injury occur: — N/A —

L) In case of accident: i. Is it RTA: [ ] Yes [ ] No — ii. Date of injury: DD MM YYYY — iii. Reported to Police: [ ] Yes [ ] No — iv. FIR no.:

v. Injury/Disease caused due to substance abuse/alcohol consumption: [ ] Yes [ ] No — vi. Test conducted to establish this. If yes attach reports: [ ] Yes [ ] No

m) In case of maternity: G — P — L — A — n) Expected date of delivery: DD MM YYYY

DETAILS OF THE PATIENT ADMITED

a) Date of admission: 06/06/2023 — b) Time of admission: HH MM — c) This is [ ] an emergency/ [✓] a planned hospitalization event

d) Expected no. of days stay in hospital: 01 Days — e) Days in ICU: Days — f) Room type: DAYCARE

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY
PART C (Revised)

TO BE FILLED IN BLOCK LETTERS

g) Per Day Room Rent + Nursing & Service charges + Patient's Diet: Rs.

h) Expected cost for investigation + diagnostics: Rs.

i) ICU Charges: Rs.

j) OT Charges: Rs.

k) Professional fees Surgeon + Anesthetist fees + Consultation charges: Rs.

L) Medicines + Consumables cost of Implants: (specify if applicable) Rs.

m) Other hospital expenses if any: As per (Omics) PKG Rs.

n) All inclusive package charges if any applicable : Rs.

o) Sum Total expected cost of hospitalization Rs. 340000/-

p. Mandatory past history of any chronic illness. If yes (since month/year)

☐	1. Diabetes	M M Y Y
☐	2. Heart Disease	M M Y Y
☐	3. Hypertension	M M Y Y
☐	4. Hyperlipidemias	M M Y Y
☐	5. Osteoarthritis	M M Y Y
☐	6. Asthma/ COPD / Bronchitis	N/A
☐	7. Cancer	M M Y Y
☐	8. Alcohol or drug abuse	M M Y Y
☐	9. Any HIV or STD / related ailments	M M Y Y

10. Any other ailment give details:

DECLARATION (PLEASE READ VERY CAREFULLY)

We confirm having read understood and agreed to the declaration of this form

a) Name of the treating doctor: DR. VARUN GOGIA

b) Qualification: MBBS MD

c) Registration No. with State code: DMC R04624

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
b. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA not governed by the terms and conditions of the policy will be paid by me.
d. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the insurer / TPA
e. I agree and understand that TPA is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/ TPA.
h. "I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim"

a) Patient's / Insured's name:

b) Contact number: 9717356211 c) Email ID: (Optional)

d) Patient's / Insured's signature:

Date: 05/06/2022 Time: H H M M

HOSPITAL DECLARATION

a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
b. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA/ Insurance Company within 7 days of the patient's discharge.
c. We agree that TPA / Insurance Company will not be Liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
d. The patient declaration has been signed by the patient or by his representative in our presence.
e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
f. We will abide by the terms and conditions agreed in the MOU.
g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility choosing separate line of treatment which is not envisaged/ considered in package).
h. We confirm that no recoveries would be made from the deposit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).
i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MOU or applicable laws.

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital.
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, Supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of Operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

Hospital seal: DMC Clinic Nagar-IV N.D.-24

Doctor's signature: Dr. Varun Gogia MBBS(AIIMS) MD(AIIMS) Director DMC Reg:- R04624

Date: 05/06/2022 Time: H H M M

The New India Assurance Co. Ltd.

Beneficiary:	Asttha Surana
Medi Assist ID:	5097000503
Relation:	Self
Date of birth:	26 Feb 1988
Employee code:	122999
Primary insured:	Asttha Surana
Policy holder:	KPMG Global Delivery Center Private Limted
Policy No:	12100034220400000008_Delivery_Ex
Policy Period:	01 Apr 2023 To 31 Mar 2024
Category:	680.Senior-Gdc
Generated On:	08 May 2023 19:22

- This card is only for identification and is not an authorization to proceed · treatment or a guarantee for payment.
- In the case of photoless identity cards issued to beneficiaries, acceptabl identity such as Aadhar Card/Passport/Driver License/ Ration Card / Vot / PAN Card should be presented at hospitals.
- This non-transferable identification card is valid at selected Network Hos will enable Card Holder to avail cashless hospitalization only on the basi preauthorization by Medi Assist.
- For the latest updated Network Hospital list, logon to www.mediassisttpa Validity of the card is subject to the holder being covered under valid pol Insurer.

Medi Assist Insurance TPA Pvt Ltd.

Tower D, 4th Floor, IBC Knowledge Park, 4/1 Bannerghatta Road, Bhavar
Bengaluru, Karnataka 560029.
CIN: U85199KA1999PTC025676
Website: www.mediassisttpa.in

The New India Assurance Co. Ltd.

Beneficiary:	Rishhabh Surana
Medi Assist ID:	5097000504
Relation:	Spouse
Date of birth:	18 Oct 1985
Employee code:	122999
Primary insured:	Asttha Surana
Policy holder:	KPMG Global Delivery Center Private Limted
Policy No:	12100034220400000008_Delivery_Ex
Policy Period:	01 Apr 2023 To 31 Mar 2024
Category:	680.Senior-Gdc
Generated On:	08 May 2023 19:22

- This card is only for identification and is not an authorization to proceed · treatment or a guarantee for payment.
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Medi Assist Insurance TPA Pvt Ltd.

Tower D, 4th Floor, IBC Knowledge Park, 4/1 Bannerghatta Road, Bhavar
Bengaluru, Karnataka 560029.
CIN: U85199KA1999PTC025676
Website: www.mediassisttpa.in

The New India Assurance Co. Ltd.

Beneficiary:	Sudha Saraf
Medi Assist ID:	5109938201
Relation:	Mother
Date of birth:	12 Apr 1964
Employee code:	122999
Primary insured:	Asttha Surana
Policy holder:	KPMG Global Delivery Center Private Limted
Policy No:	12100034220400000008_Delivery_Ex
Policy Period:	01 Apr 2023 To 31 Mar 2024
Category:	680.Senior-Gdc
Generated On:	08 May 2023 19:22

- This card is only for identification and is not an authorization to proceed · treatment or a guarantee for payment.
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Medi Assist Insurance TPA Pvt Ltd.

Tower D, 4th Floor, IBC Knowledge Park, 4/1 Bannerghatta Road, Bhavar
Bengaluru, Karnataka 560029.
CIN: U85199KA1999PTC025676
Website: www.mediassisttpa.in

The New India Assurance Co. Ltd.

Beneficiary:	Vijay Saraf
Medi Assist ID:	5109938202
Relation:	Father
Date of birth:	22 Oct 1959
Employee code:	122999
Primary insured:	Asttha Surana
Policy holder:	KPMG Global Delivery Center Private Limted
Policy No:	12100034220400000008_Delivery_Ex
Policy Period:	01 Apr 2023 To 31 Mar 2024
Category:	680.Senior-Gdc
Generated On:	08 May 2023 19:22

- This card is only for identification and is not an authorization to proceed · treatment or a guarantee for payment.
- In the case of photoless identity cards issued to beneficiaries, acceptabl identity such as Aadhar Card/Passport/Driver License/ Ration Card / Vot / PAN Card should be presented at hospitals.
- This non-transferable identification card is valid at selected Network Hos will enable Card Holder to avail cashless hospitalization only on the basi preauthorization by Medi Assist.
- For the latest updated Network Hospital list, logon to www.mediassisttpa Validity of the card is subject to the holder being covered under valid pol Insurer.

Medi Assist Insurance TPA Pvt Ltd.

Tower D, 4th Floor, IBC Knowledge Park, 4/1 Bannerghatta Road, Bhavar
Bengaluru, Karnataka 560029.
CIN: U85199KA1999PTC025676

Unique Identification Authority of India

नामांकन क्रमांक / Enrollment No.: 0000/00216/25760

To
विजय कुमार सराफ
Vijay Kumar Saraf
C-89
LAJPAT NAGAR-2
Lajpat Nagar S.O
South Delhi
Delhi 110024
9868725353

03/12/2012

3102463378

MA102463785FT

आपका आधार क्रमांक / Your Aadhaar No. :

5559 1867 8567

आधार - आम आदमी का अधिकार

भारत सरकार
Government of India

विजय कुमार सराफ
Vijay Kumar Saraf
पिता : महाबीर प्रसाद सराफ
Father : MAHABIR PRASAD SARAF
जन्म तिथि / DOB : 20/10/1959
पुरुष / Male

5559 1867 8567

आधार - आम आदमी का अधिकार

आयकर विभाग

INCOME TAX DEPARTMENT

भारत सरकार

GOVT. OF INDIA

ASTTHA SURANA

VIJAY KUMAR SARAF

26/02/1988

Permanent Account Number

CUWPS7006J

Signature

10082016

आधार

भारतीय विशिष्ट पहचान प्राधिकरण

भारत सरकार

Unique Identification Authority of India

Government of India

नामांकन क्रम / Enrollment No.: 1190/30028/33022

To
आस्था सराफ
ASTTHA SARAF
C-89
LAJPAT NAGAR-2 Lajpat Nagar S.O
South Delhi
Delhi 110024
9868725353

02/12/2012

MN109341897DF

आपका आधार क्रमांक / Your Aadhaar No. :

6805 7759 5065

आधार – आम आदमी का अधिकार

भारत सरकार
GOVERNMENT OF INDIA

आस्था सराफ
ASTTHA SARAF
पिता : विजय सराफ
Father : VIJAY SARAF
जन्म वर्ष / Year of Birth :1988
महिला / Female

6805 7759 5065

आधार – आम आदमी का अधिकार

Iclinix advanced eye care
Gogia Varun
26,national park
Delhi 110024 India
Phone: - Fax:

06 Jun 2023

Patient: Saraf Vijay kumar
Date of Birth: 01 Jan 1900
Address:
-

Id Number: 11724
Gender:
Phone:

Exam Date: 06 Jun 2023

Selected Measure : Avg	OD			Selected Measure : Avg	OS	
K1: 42.25 D @0° - K2: 43.00 D @90°	K: 42.63 D	**Measured K**	K1: 43.00 D @171° - K2: 44.00 D @81°	K: 43.50 D		
Sphere: 0.00 D	Cylinder: 0.00 D @0°	**Refraction Data**	Sphere: 0.00 D	Cylinder: 0.00 D @0°		

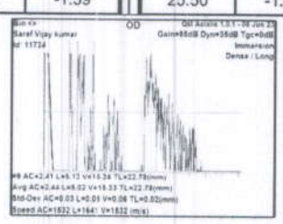
Immersion	Dense / Long	Normal Eye	Parameters	Immersion	Dense / Long	Normal Eye
A.C.: 1532m/s	L.: 1641m/s	V.: 1532m/s	**Speeds**	A.C.: 1532m/s	L.: 1641m/s	V.: 1532m/s
A.C.: 2.44mm	L.: 5.02mm	**T.L.: 22.78mm**	**Axial eye length**	A.C.: 2.29mm	L.: 5.09mm	**T.L.: 22.71mm**

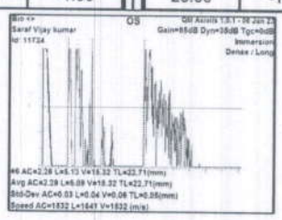
Biotech	Biotech	IOL Ref.	Biotech	Biotech
A = 118.500	A = 118.500		A = 118.500	A = 118.500
SRK-T	**SRK-II**	**Formula**	**SRK-T**	**SRK-II**
A= 118.500	A= 118.500	**Const.**	A= 118.500	A= 118.500
23.82D	23.19D	**Emmetropia (Emme)**	23.16D	22.58D
0.00D	0.00D	**Target (Ame)**	0.00D	0.00D
23.82D	23.19D	**IOL (IOL Ame)**	23.16D	22.58D

IOL (D)	Refract.(D)	IOL (D)	Refract.(D)	**Ametropia**	IOL (D)	Refract.(D)	IOL (D)	Refract.(D)
22.00	1.29	21.00	1.75		21.00	1.50	20.50	1.66
22.50	0.94	21.50	1.35		21.50	1.16	21.00	1.26
23.00	0.59	22.00	0.95		22.00	0.81	21.50	0.86
23.50	0.23	22.50	0.55		22.50	0.46	22.00	0.46
24.00	**-0.13**	**23.00**	**0.15**		**23.00**	**0.11**	**22.50**	**0.06**
24.50	-0.49	23.50	-0.25		23.50	-0.24	23.00	-0.34
25.00	-0.86	24.00	-0.65		24.00	-0.61	23.50	-0.74
25.50	-1.24	24.50	-1.05		24.50	-0.97	24.00	-1.14
26.00	-1.62	25.00	-1.45		25.00	-1.34	24.50	-1.54

Alcon Acrysoft	Alcon Acrysoft	IOL Ref.	Alcon Acrysoft	Alcon Acrysoft
A = 118.700	A = 118.700		A = 118.700	A = 118.700
SRK-T	**SRK-II**	**Formula**	**SRK-T**	**SRK-II**
A= 118.700	A= 118.700	**Const.**	A= 118.700	A= 118.700
24.10D	23.39D	**Emmetropia (Emme)**	23.43D	22.78D
0.00D	0.00D	**Target (Ame)**	0.00D	0.00D
24.10D	23.39D	**IOL (IOL Ame)**	23.43D	22.78D

IOL (D)	Refract.(D)	IOL (D)	Refract.(D)	**Ametropia**	IOL (D)	Refract.(D)	IOL (D)	Refract.(D)
22.00	1.47	21.50	1.51		21.50	1.33	21.00	1.42
22.50	1.13	22.00	1.11		22.00	0.99	21.50	1.02
23.00	0.78	22.50	0.71		22.50	0.65	22.00	0.62
23.50	0.43	23.00	0.31		23.00	0.30	22.50	0.22
24.00	**0.07**	**23.50**	**-0.09**		**23.50**	**-0.05**	**23.00**	**-0.18**
24.50	-0.29	24.00	-0.49		24.00	-0.40	23.50	-0.58
25.00	-0.65	24.50	-0.89		24.50	-0.76	24.00	-0.98
25.50	-1.02	25.00	-1.29		25.00	-1.13	24.50	-1.38
26.00	-1.39	25.50	-1.69		25.50	-1.50	25.00	-1.78





ICLINIX - Advanced Eye Care
Lajpat Nagar-IV
N.D.-24

PPN NETWORK - DECLARATION BY PATIENT/PATIENT'S ATTENDANT

Name of the Hospital **I Clinix Advanced Eye Care** Date :... 5/6/23

Address : **27/171 Vikram Vihar, Lajpat Nagar-4, Near Moolchand Metro Station, New Delhi-110024**

PATIENT NAME (BLOCK LETTERS) : VIJAY SARAF **AGE/SEX :** 63/M

IP No :..... **UHID No :**..... **Mobile No of Patient :** 9773562101

Date of Admission : 6-6-23 **Time of Admission :** 11:00

Date of Discharge : 6-6-23 **Time of Discharge :** /

Address of the Patien: /

NAME OF THE ATTENDANT : ASHA SARAF **Relationship with the Patient :** FATHER

Mobile No. of Attendant : 9773562101 **Address:** /

Declaration regarding Insurance Policy (Strike off the option which is not applicable)

(i) ***Declaration when patient has no insurance policy:***

- I declare that I do not have any insurance policy.

(ii) ***Declaration when patient has insurance policy:***

- I declare that I have following Insurance Policies

Policy No/TPA card No: 5/09938202

Insurance Company: NEW INDIA ASSURANCE

2) Whether patient opted for Eligible Room Category under Policy:
Yes / No

3) In case, policyholder wishes to avail better facility:

Name of the Additional Facility/ Provision/ Procedure/ Treatment:
----------which costs Rs
:..... (In words:
....) only.

On my own option, I wish to avail above better facility and I hereby agree to pay on my free will, after being explained in detail by the Hospital authority in my own and understandable language about the above mentioned Additional Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed PPN tariff. Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as per agreed PPN tariff rates and balance amount will be borne by myself or patient only.

I have also been explained that when room service of a category better than eligible room rent is availed by the patient, not only the difference in room rent but also an equal proportion of all other charges associated with the treatment shall be borne by me.

Signature :.....
Name of the Patient/Patient's attendant:

I Clinix Advanced Eye Care Lajpat Nagar-IV New Delhi

Signature : **Ms. Zenab**
Name of the Hospital Representative & Hospital Seal :

Mark of Excellence

E-mail : iclinix@gmail.com

iCLINIX
Advanced Eye Care
"Expert Care by AIIMS Alumni"
Centre for Retina & Lasers

Dr. Varun Gogia
MBBS (AIIMS), MD (AIIMS)
Senior Registrar (AIIMS)
Clinical Observer, Cleveland Clinic, USA
Honorary Visiting Consultant : Asan Eye Clinic, Dushanbe, Tajikistan
Senior Consultant Ophthalmology, Fortis C-DOC

Discharge Summary

Name : Mr. Vijay Kumar Saraf		**Age/Sex :** 63 YRS. / M	**ICD :H:25**	**UHID NO :** 11724
DOA : 06-Jun-2023	**Time :** 11:28 am	**DOS:** 06-Jun-2023	**DOD :** 06-Jun-2023	**Time :** 1:26 pm
MLC : NA	**FIR No:** NA	**Presenting Complaint :** BLURRING OF VISION		**IPD No :** 6743
Duration : 20 Minuts		**Reason :** Nil		
Past Medical Surgery History				
Provisional Diagnosis		LE :- CATARACT		
Special Investigation				
Procedure performed		LE :- MICS + IOL		
Course in the Hospital (Complication if any): Uneventful				

Instructions at Discharge :

PATCH REMOVAL AFTER 4 HOURS

Treatment Advice (All Medicines should be started from today as explained)

1 **COMBIFLAM TAB [** IBUPROFEN+PARACETAMOL **]**
as required for 1 Day

2 **PREDMET [** PREDNISOLONE ACETATE OPTHALMIC SUSPENSION USP **]**
6 times in a day for 7 days,
4 times in a day for 7 days,
2 times in a day for 7 days,
1 time in a day for 7 days. for 28 Days

3 **MO-FLOREN [** MOXIFLOXACIN EYE DROP IP **]**
6 times in a day for 7 days
4 times in a day for 14 days for 21 Days in Left Eye

4 **HYLA PF [** SODIUM HYALURONATE OPTHALMIC SOLUTION 0.01% **]**
four times in a day for 90 Days in Left Eye

5 **TROPTHA-P [** TROPICAMIDE & PHENYLEPHRINE HYDROCHLORIDE OPHTHALMIC SOLUTION **]**
four times in a day for 2 Days in Left Eye

6 **LOTEL EYE OINTEMENT [** LOTEPREDNOL ETABONATE OPTHALMIC OINTMENT 0.5% **]**
at bed time for 3 Days in Left Eye

Condition of eye at the time of discharge:- Stable
Follow up after 2 days

- To report immediately in case of excessive pain, decrease in vision, excessive redness, or injury to eye any time after surgery.
- Avoid constipation, excessive coughing, lifting heavy weight's, injury to the eye, wetting of eye/head bath.

Surgeon	**Dr.Varun Gogia**	Dr. Varun Gogia MBBS(AIIMS), MD(AIIMS) Director
Co Surgeon Name	**Dr.Varun Gogia**	
Department / Speciality	**MBBS(AIIMS), MD(AIIMS) (Ophthalmology)**	Delhi Reg:- R04624 **Signature**

Patient / Attendant's Signature

Nutritional Advice: Continue normal diet/as advised by treating physician.
For Emergency please contact:Mobile no 8700159654/01141610593

#SN60WF | D Size | AcrySof™ IQ IOL | GTIN 00380655093269
+23.5D | $Ø_T$ 13.0mm | $Ø_B$ 6.0mm
SN 25508399 085 | UDI | 2027-10-14
UV & BLUE LIGHT FILTER
Alcon

Our Centers
27/171, Vikram Vihar,
Near Moolchand Metro Station,
Lajpat Nagar-IV, New Delhi-110024
Phone : 011-41610593,
Mobile : 9289665675

New Delhi Address
26, National Park,
Near Moolchand Metro Station,
Lajpat Nagar-IV, New Delhi-110024
Phone : 011-41610593,
Mobile : 9289665675

Shakti Nagar Address :-
23/7, Block-23,
Shakti Nagar,
New Delhi-110007
Mobile : 9318433080

Panipat Address :-
Opposite Hyderabadi
Hospital, Sanoli Rd,
Panipat, Haryana 132103,
Landmark : Sanjay Chowk
Mo.: 8595364670

Gurgaon Address :-
1325 (1st Floor),
Sector-45, Noble Eye Care,
Gurgaon-122002
Phone : 011-41610593,
Mobile : 9311528173

Mark of Excellence

E-mail : iclinix@gmail.com

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QCI Accredited

Dr. Varun Gogia
MBBS (AIIMS), MD (AIIMS)
Senior Registrar (AIIMS)
Clinical Observer, Cleveland Clinic, USA
Honorary Visiting Consultant : Asan Eye Clinic, Dushanbe, Tajikistan
Senior Consultant Ophthalmology, Fortis C-DOC

Bill Cum Receipt

To,

MEDIASSIST INSURANCE TPA PVT. LTD

Bill No	IAE\23-24\IPD\362	**Bill Date**	06/Jun/2023 01:29 PM
Patient ID	11724	**Doctor Name**	Dr.Varun Gogia
Date of Admission	06/Jun/2023	**Discharge Date**	06/Jun/2023
Patient Name	Mr. Vijay Kumar Saraf	**Age/Sex**	63 Yrs / M
S/O	M.p Saraf		
Address	C-89 Lajpat Nagar New Delhi,New Delhi		

includes this following charges against

CATARACT SURGERY

Insurance Company	The New India Assurance Company Ltd		
Employee Name	Asttha Surana	**Relation With ESM**	FATHER
Insurance No	12100034230400000006_Delivery		
Hospital Reg No.	DGHS/NH/1393		
Service Tax No.	AQNPG1394ASD001		
Pan No.	AQNPG1394A		
Claim Id / Authoraziation No.	33085707		
Policy No.	12100034230400000006_Delivery		

SR.NO.	SERVICE NAME	RATE	QTY	AMOUNT	NET AMT
1	MICS + FOLDABLE IOL	34000	1	34000	34000.00

Credit Amount In (Words) Rupees Thirty-Four Thousand Only.
Towards : MEDIASSIST INSURANCE TPA PVT. LTD

Total Amount	34000.00
Net Bill Amount	34000.00
Balance Amount	34000.00

Signature/Thumb of Patient/Attendant

I clinix Advanced Eye Care

Authorized Signatory

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